FINANCIAL POLICY

1. Our Billing Services:

Our practice will bill your primary insurance. In order to properly bill your insurance company, we must have complete and accurate insurance. We have 90 days to file insurance claims on your behalf. Failure to provide current and accurate insurance information may result in patient responsibility for the entire bill. Cash, personal check or credit cards are accepted methods of payment. We will file charges on your behalf with most health plans. We are participating providers for most insurers in Colorado, but not all insurers – please contact your insurance carrier to ensure we are in network with your plan. We also ask that you confirm your health plan information at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT IMMUNOE HEALTH CENTERS AND HORIZON PRIMARY CARE ARE UNABLE TO PROVIDE TREATMENT, BILL OR RECEIVE PAYMENT FROM DENVER HEALTH MEDICAID, KAISER MEDICAID OR KAISER HEALTH PLANS.

2. Behavioral Health Services

Horizon Pediatrics is partnering with MHCD: Mental Health Center of Denver to provide comprehensive behavioral health services. These voluntary services may include screenings for behavioral concerns, consultation with a behavioral health specialist, brief interventions for your child or family and parenting education and support. By providing these behavioral health services within your medical home at Horizon, we can provide early interventions that may help your child be more successful at home and school. For visits with our Behavioral Health Consultant (BHC) please confirm insurance coverage prior to the visit, as some private insurance plans do not currently cover this service.

3. Secondary & Tertiary Insurances.

If applicable, secondary & tertiary insurance claims will be filed on your behalf. You must make us aware of any secondary & tertiary coverage that you have at the time of your appointment. Please note that we reserve the right to forward to the patient all secondary & tertiary charges which have not been paid within 45 days of submission. At such time, these charges will be the responsibility of the patient, and the patient must follow up with the secondary & tertiary carriers for reimbursement.

4. Auto Accident:

If your injury is a result of an auto accident, we will bill your medical policy. It will be the auto policy's responsibility to reimburse the medical policy.

5. Liability Injury:

If your injury is a result from another party's negligence, we will bill your medical policy. It will be the other involved parties to reimburse the medical policy.

6. Worker's Compensation:

If your injury is due to an accident in your work place, please inform the receptionist immediately. We are not authorized to treat you for this type of claim. You will need to contract your supervisor for instructions on how to file a worker's compensation claim. We regret any inconvenience this may cause.

7. Claim Processing Issues:

Should you have claims issues, we will assist you as best we can to ensure they are resolved. Any claims that become more than 4 months past due will become the patient's responsibility and payment will be required from the guarantor. Reimbursement for these claims will need to be resolved through the insurance company and the insured.

8. Co-Pays, Deductibles, and Co-Insurances:

Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf unless there is a showing of financial hardship.

9. Payment Options:

We accept cash, check, Visa, Master Card, American Express and Discover. Our patient portal is also available to make payments on your account.

10. Infusion Patient Co-Pays, Deductibles, and Co-Insurances:

Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. WE REQUIRE ANY PRIOR ACCOUNT BALANCES TO BE PAID IN FULL PRIOR TO THE START OF INFUSION SERVICES. IN ADDITION, YOU WILL BE REQUIRED TO PAY 20% OF YOUR OUTSTANDING DEDUCTIBLE/CO-INSURANCE/MAX OUT OF POCKET PRIOR TO THE START OF INFUSION SERVICES.

11. Payment may be requested PRIOR to service:

We accept cash, check, or credit card for payment of your estimated responsibility at the time of service. Insurers reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are processed by the insurer. We will send patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services will be provided. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.

12. Private Pay Patients:

Please be prepared to pay for services rendered at the time of service.

13. Statements:

We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have any questions or concerns regarding your statement, please contact our billing department at 303-224-4686.

14. Returned Checks:

There is a $40.00 fee for any checks returned by the bank.

15. No Show Fees:

The following fee will apply if you do not show up for your scheduled appointment: $35.

16. Financial Payment Arrangements:

If you are financially unable to make payments in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Payment Plan Agreement.

17. Financial Hardship:

IMMUNOe Health Centers and Horizon Primary Care cares about the patients we treat, wand we encourage patients who are not able to afford their medical bills to discuss these challenges with our clinic. It is the policy of IMMUNOe Health Centers and Horizon Primary Care to treat all our patients equitably and with dignity in accordance with the Financial Hardship Policy. Discount offered to patients are intended for residents of the community served by IMMUNOe Health Centers and Horizon Primary Care. Our practice reserves the right to modify out Patient Discount Policy at any time.

18. Collections:

If payment is not received within our 2 statement cycles (approximately 60 days or more from your date of service), and/or if you are not current on an agreed-upon payment plan, your account is considered delinquent and may be referred to an outside collection agency. We will discharge patients who have been referred to an outside collection agency. Once the account has been paid in full, patients may resume care on a payment-at-the-time-of-service basis.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Name of Patient/Legal Guardian: _____

Signature: _____ **Date:** _____

OFFICE USE ONLY (PATIENT INFO)

Patient Name: _____ **D.O.B.:** _____

Account Number: _____